No. 88-1503

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L. AND JOYCE CRUZAN,

Petitioners,

v.

DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,

Respondents,

v.

THAD C. MCCANSE, GUARDIAN AD LITEM,

Respondent,

On Writ of Certiorari to the Missouri Supreme Court

BRIEF OF JACK BUTLER AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

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MOTION FOR LEAVE TO FILE A BRIEF AS AMICUS CURIAE ON BEHALF OF RESPONDENT

Amicus hereby respectfully moves for leave to file a brief amicus curiae in the present case. Requested consent of the parties is expected but has not yet been received and filed. When filed, it will make this motion unnecessary.

INTEREST OF AMICUS CURIAE

Several years ago, Jack Butler, father of a preschool boy, had about a month to live unless someone else died. He was waiting for a new heart because his heart was failing fast. After some disappointments, he was lucky because someone else was very unlucky. Next time, his son will be older and he may not have a high enough priority. Nevertheless, he urges this Court to rule in favor of the sanctity of life, even if some, like himself, must suffer.

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SUMMARY OF ARGUMENT

Your eighteen year old son has been in a coma for three months. Who do you call in to assist your present doctors? A brain specialist? Or Dan Marino, who specializes in throwing footballs into end zones rather than medical practice? Don´t be hasty in making the decision. Although knowledge of the brain is increasing at its fastest rate in history, so little is known by the brain specialists that Marino might be your best bet. Don Doyle called in Dan Marino whose pep talk is credited with rousing Brent Doyle from coma.

Is it unfair to say that little is known about the brain? A doctor was confident that Carrie Coons, 36 of Rensselaer NY was in an irreversible vegetative state. She had been unconscious five months. It was time to

petition the court to remove her feeding tubes. She was the first New Yorker given this dubious honor. Both stories in the same newspaper on the same day indicate that it is sometimes premature to write off unconscious people [who may hear, even if unable to respond] as vegetables. The trouble for this Court, of course, is does this court have the wisdom to write an unenumerated US Constitutional Right that will permit the killing of those who will not revive, while sparing those who will revive. Don´t ask the doctors for help. They don´t know either.

These two examples highlight the wisdom of the Hippocratic oath which divided the medicine men into two classes, doctors who healed and sorcerers who killed.

Nutrition and hydration, even via tubes differ in kind from medical

treatment. They treat no medical condition, but are aspects of normal care. Means of reception cannot be a good method of differentiation or poison administered by needle will be medical care, not homicide.

The only reason to eliminate nutrition and hydration in the present case is to kill Nancy Cruzan. Malcolm Muggeridge argues in "The Humane Holocaust", taken from President Reagan´s 1984 book, "Abortion and the Conscience of the Nation" that a killing such as is sought in the present case is anti Christian, and destroying life out of alleged compassion is likely to become a holocaust. He points to the Nazi experience triggered by "The Release of the Destruction of Life Devoid of Value" by Hoche and Binding and suggests instead that love of the disabled is the answer.

THE HUMANE HOLOCAUST

by MALCOLM MUGGERIDGE

One of the most curious encounters I ever had in a television studio was participating in a BBC program set up when the South African surgeon, Dr. Christiaan Barnard, had just carried out his first heart-transplant operation in the Groote Schuur Hospital in Pretoria. The program was billed as "Dr. Barnard Faces His Critics," which, as I well knew, was BBC-ese for "Dr. Barnard Faces His Adulators," as, indeed, proved to be the case. One of the great contributions of television to preparing the way for the collectivist-authoritarian way of life towards which all western countries are, in their different ways, sleep-walking, is its capacity to present consensus in terms of ostensible controversy.

The studio was packed with medical practitioners of one sort and another, including distinguished figures like Lord Platt, all of whom were in a state of euphoria about Dr. Barnard's achievement. As befitting such an occasion, the Church was represented, in the person of the appropriately named Dr. Slack, who on its behalf gave full approval, not just to the particular transplant operation that was being celebrated, but to transplants in general as and when required, whatever the organ concerned. In the event, I found myself pretty well the lone representative of the critics Dr. Barnard had been billed as meeting.

When the time came for me to put a question, one shaped itself insistently in my mind. Was Dr. Barnard, I asked him, the first surgeon to chance his arm with a heart-transplant operation,

whereas elsewhere there were still qualms and hesitations, because in South Africa the doctrine of apartheid had devalued human flesh, reducing it from something God had deigned to put on, to a mere carcass?

The question, when I put it, was extremely ill-received. Some of the doctors present went so far as to manifest their displeasure by hissing, while Lord Platt rose to apologize to Dr. Barnard, pointing out that I represented no one but myself, and that he, and he was sure all the others in the studio, would wish to dissociate themselves from my insulting question. Dr. Barnard himself, I should imagine deliberately, misunderstood what I had asked, assuming that what troubled me was a fear lest he had transplanted a black African's heart in a

white African's body. In fact, the donor was a white girl.

As Dr. Barnard made no serious effort to answer my question, I persisted, to the further displeasure of the doctors, pointing out that his and their attitude showed little sense of the sanctity of life, which, in the Hippocratic oath they had all presumably taken, they had sworn to respect. As a Christian, I said, I worshipped a God who, according to the New Testament, could not see a sparrow fall to the ground without concern, and quoted Blake's beautiful couplet in the same sense:

A Robin Redbreast in a Cage
Puts all Heaven in a Rage.

This caused a titter of amusement, and I lapsed into silence. It is the usual practice after such programs for all the participants to make for the hos-

pitality room, there to continue the discussion over a drink. For once, I just made off, having no taste for any further contact with Lord Platt, Dr. Slack and the others. It was comforting subsequently to receive a letter from a doctor who had once worked at Groote Schuur Hospital, but had left, he explained, because he found the attitude there to surgery to be more veterinary than medical.

Dr. Barnard's own attitude to his surgery is well conveyed in his autobiography, *One Life*. His account of his first post-mortem is almost lascivious; as are his first essays with animals, whose snug little abattoir, he tells us, "smelt of guinea pigs, rabbits and hundreds of mice. Yet it was like heaven, and even today those odours excite me with memories of our first days, so

filled with hope and dreams." One of his dreams was to "take a baboon and cool him down, wash out his blood with water, then fill him up with human blood;" another, to graft a second head on a dog, as has allegedly – though I don't believe it – been done in the USSR.

All this was but a prelude to the great moment when the two hearts – the donor's lively one and the recipient's failing one – were ready, and all was set for the first heart-transplant operation. "This isn't a dog," Dr. Barnard reflected exultantly. *"It's a man!"* and then a doubt seized him; was he, after all, entitled to experiment with a human being? His hesitation lasted only for a few seconds, though; the excitement of the occasion, with, as it seemed, the whole world looking on, restored his confidence, and he got to work with his knife.

As it happened, there was one other moment of, if not doubt, then wonderment. The donor, Denise Darvall, was in a respirator; it would be necessary to stop the respirator, and take her heart, which was still beating. Another doctor, de Klerk, was participating in the operation; he wanted Denise's kidneys, but Dr. Barnard made it quite clear what were the priorities. His instructions were to "cut for the heart and let de Klerk worry about his kidneys afterwards." In the event, having stopped the respirator, they waited for the heart to stop beating before transferring it to the recipient, Washkansky. "What intermingling of mythology and ritual," Dr. Barnard asks himself, "prevented us from touching a heart in a body which had been declared clinically dead?" and, like Pontius

Pilate on another dramatic occasion, does not wait for an answer.

Washkansky received Denise's heart, and, presumably, de Klerk her kidneys. The heart worked, and the patient, in a manner of speaking, lived. Congratulatory messages came pouring in; the television cameras rolled – exclusive TV rights had been disposed of, resulting in unseemly scenes in the hospital. Washkansky, but not Denise, was brought into the act; the arc lights shone on him, a meeting with his loving relatives was set up, and he succeeded in uttering a few cheerful words into a specially sterilized microphone. At the end of eighteen days, he thankfully expired. "They're killing me," he managed to get out before he died. "I can't sleep, I can't eat, I can't do anything. They're at me all the time with pins and needles

… All day and all night. It's driving me crazy."

Washkansky's successor, Dr. Philip Bleiberg, a dentist, managed to survive for two years though his private account of how he fared roughly coincided with his predecessor's. In the published version – these rights, too, had been disposed of – he was obliged to put on a brave face, and only three weeks after he had received his new heart, he was able to tell an expectant world that he had succeeded in having sexual intercourse. It was the twentieth century certification of being fully alive: *copulo ergo sum*. Behind the mania about transplant operations, lies the mad hope that in due course genital transplants may become possible—new ballocks in old crotches – so that sated lechers can begin all over again.

The Barnard experience stayed in my mind, and as I thought about it, I realized that it amounted to a sort of parable illustrating a basic dilemma of our time, as between the sanctity of life as conceived through the Christian centuries, and the quality of life as conceived in a materialistic society. Those doctors in the BBC studio rejoicing in the new possibilities in surgery that Dr. Barnard seemed to have opened up, saw human beings as bodies merely, and so capable of constant improvement, until at last perfection was achieved.

No more sick or misshapen bodies, no more disturbed or twisted minds, no more hereditary idiots or mongoloid children. Babies not up to scratch would be destroyed, before or after birth, as would also the old beyond repair. With the developing skills of modern medicine, the

human race could be pruned and carefully tended until only the perfect blooms - the beauty queens, the mensa I. Q.'s, the athletes - remained. Then at last, with rigid population control to prevent the good work being ruined by excessive numbers, affliction would be ended, and maybe death itself abolished, and men become, not just like gods, but in their perfect mortality, very God.

Against this vision of life without tears in a fleshly paradise, stands the Christian vision of mankind as a family whose loving father is God. Here, the symbol is not the perfected body, the pruned vine, the weeded garden, but a stricken body nailed to a cross, signifying affliction, not as the enemy of life, but as its greatest enhancement and teacher. In an army preparing for battle the unfit are indeed discarded, but in a

Christian family the handicapped are particularly cherished, and give special joy to those who cherish them.

Which vision are we for? On the one hand, as the pattern of our collective existence, the broiler house or factory-farm, in which the concern is solely for the physical well-being of the livestock and the financial well-being of the enterprise; on the other, mankind as a family, all of whose members, whatever physical or mental qualities or deficiencies they may have, are equally deserving of consideration in the eyes of their creator, and whose existence has validity, not just in itself, nor just in relation to history, but in relation to a destiny reaching beyond time and into eternity. Or, in simple terms, on the one hand, the

quality of life; on the other, the sanctity of life.

The sanctity of life is, of course, a religious or transcendental concept, and has no meaning otherwise; if there is no God, life cannot have sanctity. By the same token, the quality of life is an earthly or worldly concept, and can only be expressed legalistically, and in materialistic terms; the soul does not come into it. Thus a child conceived in conditions of penury, or with a poor heredity, or against its mother's wishes, or otherwise potentially handicapped, may be considered as lacking the requisite quality of life prospects, and so should not be born. Equally, it follows, at the other end of our life span, that geri-

atrics unable any longer to appreciate what this world has to offer in the way of aesthetic, carnal and egotistic satisfaction, in other words, by virtue of their years losing out on quality of life, should be subjected to euthanasia or mercy-killing, and discreetly murdered.

On this basis, for instance, Beethoven would scarcely have been allowed to be born; his heredity and family circumstances were atrocious, a case history of syphilis, deafness and insanity. Today, his mother's pregnancy would be considered irresponsible, and as requiring to be terminated. Dr. Johnson, when he was born, was scrofulous, and already showed signs of the nervous disorders which plagued him all his life. He, too, under present conditions, would probably not have been allowed to survive.

Indeed, a good number of the more notable contributors to the sanctity of life, like Dr. Johnson, would have failed to make the grade on quality of life, the supreme example being the founder of the Christian religion. Imagine a young girl, unmarried and pregnant, who insists that the Holy Ghost is responsible for her pregnancy, and that its outcome, according to a vision she has been vouchsafed, would be the birth of a long-awaited Messiah. Not much quality of life potential there, I fancy, and it wouldn't take the pregnancy and family-planning pundits long to decide that our Saviour, while still at the fetus stage, should be thrown away with the hospital waste.

These are hypothetical cases; near at hand, we have been accorded, for those that have eyes to see, an object lesson

in what the quest for quality of life without reference to sanctity of life, can involve. Ironically enough, this has been provided by none other than the great Nazi holocaust, whose TV presentation has lately been harrowing viewers throughout the Western world. In this televised version, an essential consideration has been left out – namely, that the origins of the holocaust lay, not in Nazi terrorism and anti-semitism, but in pre-Nazi Weimar Germany's acceptance of euthanasia and mercy-killing as humane and estimable. And by one of those sick jokes which haunt our human story, just when the penitential holocaust was being shown on American, and then on German and other Western European TV screens, a humane holocaust was getting under way, this time in the countries that had defeated Hitler's Third Reich, and, at the

Nuremberg War Crimes Tribunal, condemned as a war crime the very propositions and practices with which the Nazi holocaust had originated, and on which the humane one was likewise based.

No one could have put the matter more cogently and authoritatively than has Dr.. Leo Alexander, who worked with the Chief American Counsel at the Nuremberg Tribunal:

Whatever proportion these crimes finally assumed, it became evident to all who investigated them that they had started from small beginnings. The beginnings at first were merely a subtle shift in emphasis in the basic attitudes of the physicians. It started with the acceptance of the attitude, basic in the euthanasia movement, that there is such a thing as life not worthy to be lived. This attitude in its early stages con-

cerned itself merely with the severely and chronically sick. Gradually, the sphere of those to be included in this category was enlarged to encompass the socially unproductive, the ideologically unwanted, the racially unwanted, and finally all non-Germans. But it is important to realize that the infinitely small wedged-in lever from which the entire trend of mind received its impetus was the attitude towards the non-rehabilitable sick [my emphasis].[1]

Surely some future Gibbon surveying our times will note sardonically that it took no more than three decades to transform a war crime into an act of compassion, thereby enabling the victors in the war against Nazi-ism to adopt the very

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[1] From a paper – "Medical Science Under Dictatorship"–by Dr. Alexander, now a Boston psychiatrist, which appeared in the *New England Journal of Medicine* of July 4, 1949.

practices for which the Nazis had been solemnly condemned at Nuremberg. Then they could mount their own humane holocaust, which in its range and in the number of its victims may soon far surpass the Nazi one. Nor need we marvel that, whereas the Nazi holocaust received lavish TV and film coverage, the humane one just goes rolling along, largely unnoticed by the media.

It all began in the early twenties, in the decadent years in the post-1914-18 war Germany which have been so glorified by writers like Christopher Isherwood, but which, as I remember them at first hand, were full of sinister portent for the future. All the most horrible and disgusting aspects of the last decades of the twentieth century – the pornography, the sadism, the violence, the moral and

spiritual vacuum – were already in evidence there.

In this sick environment, the notion of mercy-killing was put forward in 1920 in a book entitled *The Release of the Destruction of Life Devoid of Value* by Alfred Hoche, a reputable psychiatrist, and Karl Binding, a jurist. The authors advocated killing off "absolutely worthless human beings," pointing out that the money spent on keeping them alive thus saved could be used to better purpose – for instance, on helping a young married couple to set up house. Frederick Wertham, in his scholarly and deeply disturbing book, *A Sign For Cain,* says that the Hoche-Binding book influenced, or at least crystallized, the thinking of a whole generation.

From these beginnings, a program of mercy-killing developed which was initi-

ated, directed and supported by doctors and psychiatrists, some of them of considerable eminence – all this when the Nazi movement was still at an embryonic stage, and Hitler had barely been heard of. Initially, the holocaust was aimed, not against Jews or Slavs, but against handicapped Aryan Germans, and was justified, not by racial theories, but by Hegelian utilitarianism, whereby what is useful is *per se* good, without any consideration being given to Judeo-Christian values, or, indeed to any concept whatsoever of Good and Evil. Subsequently, of course, the numbers of the killed rose to astronomical figures, and the medical basis for their slaughter grew ever flimsier; but it should never be forgotten that it was the euthanasia program first organized under the Weimar Republic by the medical profession, which led to and

merged into the genocide program of 1941-45. "Technical experience gained first with killing psychiatric patients," Wertham writes, "was utilized later for the destruction of millions. The psychiatric murders came first."

Can this sort of thing happen in countries like Canada and England and the United States? In my opinion, yes; in fact, it is already happening. Abortion on demand has come to be part of our way of life; in the world as a whole there are estimated to have been last year something in the neighborhood of fifty million abortions – an appalling figure, which, however, with media help, did not loom very large, or throw any kind of shadow over 1979 as the Year of the Child. To quieten any qualms Christians might have about it, an Anglican bishop has devised an appropriate prayer for use

on the occasion of an abortion which received the approval of the Archbishop of Canterbury. It runs, "Into Thy hands we commit in trust the developing life we have cut short," though whether with the idea of God's continuing the interrupted development elsewhere, or of extinguishing in Heaven the life that was never born on earth, is not clear. In the case of euthanasia, a hymn may seem more in keeping with the occasion – "The life Thou gavest, Lord, we've ended …."

Euthanasia, it is true, has not yet been legalized except in some American states, but notoriously it is being practiced on an ever-increasing scale. Already among old people there is reluctance to go into government institutions for fear of being done away with. As for governments – hard-pressed financially as they all now are, and unable to economize

on defense expenditure for fear of laying themselves open to the charge of jeopardizing national security, or on welfare expenditure for fear of losing votes – will they not look ever more longingly at the possibility of making substantial savings by the simple expedient of mercy-killing off the inmates of institutions for the incurably sick, the senile old, the mentally deranged and other such? With abortions and family-planning ensuring a zero population growth rate, and euthanasia disposing of useless mouths among the debilitated old, besides mopping up intervening freaks, the pursuit of happiness should be assured of at any rate financial viability.

In Christian terms, of course, all this is quite indefensible. Our Lord healed the sick, raised Lazarus from the dead, gave back sanity to the deranged,

but never did He practice or envisage killing as part of the mercy that held possession of His heart. His true followers cannot but follow His guidance here. For instance, Mother Teresa, who, in Calcutta, goes to great trouble to have brought into her Home for Dying Derelicts, castaways left to die in the streets. They may survive for no more than a quarter of an hour, but in that quarter of an hour, instead of feeling themselves rejected and abandoned, they meet with Christian love and care. From a purely humanitarian point of view, the effort involved in this ministry of love could be put to some more useful purpose, and the derelicts left to die in the streets, or even helped to die there by being given the requisite injection. Such calculations do not come into Mother Teresa's way of looking at things; her

love and compassion reach out to the afflicted without any other consideration than their immediate need, just as our Lord does when He tells us to feed the hungry, shelter the homeless, clothe the naked. She gives all she has to give at once, and then finds she has more to give. As between Mother Teresa's holocaust of love and the humane holocaust, I am for hers.

There is an episode in my own life which, though it happened long ago, provides, as I consider, a powerful elucidation of the whole issue of euthanasia – a study, as it were, in mercy-living in contradistinction to mercy-killing. Some forty years ago, shortly before the outbreak of the 1939-45 war, the person whom I have most loved in this world, my wife Kitty, was desperately ill, and, as I was informed by the doctor attending her, had

only an outside chance of surviving. The medical details are unimportant; probably today, with the great advances that have taken place in curative medicine, her state would not be so serious. But as the situation presented itself then, she was hovering between life and death, though, needless to say, there was no voice, as there might well be nowadays, to suggest that it might be better to let her go.

The doctor explained that an emergency operation was essential, and, in honesty, felt bound to tell me that it would be something of a gamble. Her blood, it appeared, was so thin as a result of a long spell of jaundice that before he operated a blood-transfusion was desperately needed – this was before the days of plasma. As he said this, an incredible happiness amounting to ecstasy

surged up inside me. If I could be the donor! My blood-count was taken, and found to be suitable; the necessary gear was brought in, very primitive by contemporary standards – just a glass tube one end of which was inserted in her arm and the other end in mine, with a pump in the middle drawing out my blood and sending it into her. I could watch the flow, shouting out absurdly to the doctor: "Don't stint yourself, take all you want!" and noting delightedly the immediate effect in bringing back life into her face that before had seemed grey and lifeless. It was the turning point; from that moment she began to mend.

At no point in our long relationship has there been a more ecstatic moment than when I thus saw my life-blood pouring into hers to revivify it. We were at one, blood to blood, as no other kind of

union could make us. To give life–this was what love was for; to give it in all circumstances and eventualities, whether God creating the universe, or a male and female creating another human being; whereas to destroy life, be it in a fertilized ovum one second after conception, or in some octogenarian or sufferer from a fatal illness, was the denial of life and so the antithesis of love. In life-denying terms, as we have seen, compassion easily becomes a holocaust; garden suburbs and gulags derive from the same quest for quality of life, and the surgeon's knife can equally be used to sustain and extinguish life. Dostoevski makes the same point: "Love toward men, but love without belief in God, very naturally leads to the greatest coercion over men, and turns their lives completely into hell on earth." We should

never forget that if ever there was a killing without mercy, a death without dignity, it was on Golgotha. Yet from that killing, what a pouring out of mercy through the subsequent centuries! From that death, what a stupendous enhancement of human dignity!

NUTRITION AND HYDRATION VIA TUBES DIFFER IN KIND FROM MEDICAL TREATMENT

The nature of nutrition and fluids, when provided by intraveneous line (IV), nasogastric (NG) or stomach tube, may be different from that proposed by most ethicists today because of the finalities and teleological orientations of feeding and hydration provided by these methods, rather than by the manner in which they are provided. Even when nutrition and fluids are given by these means, they are basic resources of the body and their provision would be an aspect of normal care and basic, routine patient maintenance – they are not "medical treatments."

To those who claim that nutrition and fluids are medical treatments when administered by an IV, NG, or stomach tube, what is the clinical condition that

they treat? Nutrition and fluids are aspects of normal care and are not medical treatments because they act differently on the body than do medical treatments. Nutrition and fluids are extrinsic natural resources of the body that are used universally by the body to sustain its natural functions and support its natural defenses against diseases.

When nutrition and fluids are provided by hyperalimentation, however, this would be considered an ordinary medical treatment because it replaces the digestive function of the body and because it requires more than ordinary competent nursing skill to be administered. Techniques of providing hyperalimentation have improved so rapidly that hyperalimentation must be considered today as an ordinary medical treatment. Because the harm involved in its removal is so great,

it is hard to see how the benefits of its removal could outweigh the effects of its withdrawal. In practice, this means that there are virtually no circumstances where hyperalimentation should not be provided.

Medical treatments are artificially administered impediments to either previously existing pathological conditions or to future possible lethal conditions. Directly, proximately, and immediately nutrition and fluids do not cure any clinically diagnosable pathological conditions, and they meet the need of the body for basic resources. Indirectly and remotely, they might impede clinically diagnosable conditions, but this is not their direct, proximate, or immediate teleological orientation. Medical treatments, on the other hand, directly, proximately, and immediately cure, remedy, or

palliate clinically diagnosable conditions, and unlike nutrition and fluids, are only indirectly and remotely natural extrinsic resources of the body. Nutrition and fluids might temporarily alleviate pain and indirectly have some neurological impact, but they do this only because they meet a need of the body for basic and extrinsic resources.

The lack of the basic resources of the body is not a clinical condition – when most people feel pangs in their midsection they consult their refrigerators rather than their physicians! When the need for basic resources is extreme, the body can be so weakened that pathological conditions break out, but ordinary hunger and thirst are not clinical conditions. Thus, the mode of provision of nutrition and fluids does not make them a medical treatment. If that were not the case,

then one would be logically committed to the view that the provision of poisons by a hypodermic injection would be a medical treatment, while providing it orally would be homicide.

Assisted feeding is different from the use of respirators for a number of reasons. Respirators assist the inhaling and exhaling functions of the body. On the other hand, assisted feeding by IV, NG or stomach tube does not assist the swallowing function, but replaces it. Assisted feeding tubes are more like a tracheal tube, which bypasses an impediment to breathing, than they are like a respirator, which assists a natural bodily function. Assisted feeding is comparable to tracheal tubes in that both are passive devices, unlike respirators, and they both bypass blockages, but do not substitute for bodily functions.

Tracheal tubes, or oxygen masks for that matter, are used whenever their mere provision prevents an otherwise healthy person from suffocating to death. An artificial stomach, which converted extrinsic basic resources of the body into materials that could be directly used by the body, would be comparable to a respirator.

Assisted feeding by IV, NG or stomach tube, is comparable to assisted respiration in some aspects, but it is similar to other forms of patient care also. In some instances, assisted feeding requires some professional medical skill to provide, but once provided, the act of giving nutrients and fluids is an aspect of normal care. It is similar to the use of contact lenses, for the making of contact lenses requires medical and professional skill, but once they are made, the

act of using them requires little more than ordinary care and caution. Assisted feedings are aspects of normal care that should be distinguished from the use of respirators.

Morally speaking, assisted feeding by IV, NG or stomach tube, is also significantly different in its functioning from a respirator. When a respirator is removed, it is commonly the case that the person continues to breathe without it. But the definitive and absolute removal of feedings guarantees that a person could not go on living. Removal of respiratory assistance does not necessarily and universally entail death, while removal of assisted feeding guarantees death in all instances. This is so because removing food and fluids creates a new and independent lethal circumstance for the person, while removal of respira-

tory assistance permits a previously existing pathological condition to run its course if it will. Definitively and absolutely removing food and fluids is morally identical to placing a plastic bag over a person's head because they both guarantee death in a relatively short period of time.

Because feeding is an extrinsic basic resource of the body and an aspect of normal care when given by IV, NG or stomach tube, life-sustaining nutrition and fluids should be given whenever it is medically possible to do so. If a person is to succumb, the morally acceptable objective is to have the person die from the underlying pathological condition, and not from a lack of basic resources of the body. To bring a person to death, who is not at death's doorstep, by withdrawing food and fluids is to directly

cause death and is not a case of allowing the person to die from an underlying pathological condition.

Assisted feeding should be provided when it is life-sustaining and when medically possible, because it is not at all clear that it can be withheld without directly intending to inflict death. Moreover, it would seem that there would never be anything immoral in providing life-sustaining and medically providable nutrition and fluids to patients, and that removing these from patients who could continue to live with their mere provision would clearly risk direct killing.

In contrast to the views of some authors, there is a moral difference between allowing to die and killing by benign neglect or omission. Morally acceptable "allowing to die" occurs when a

causa prohibens (prohibiting cause) is removed, thus permitting a previously existing pathological condition to proceed unimpeded. But when one kills another by culpable omission or benign neglect, one establishes a new and independent lethal cause either by positive means or by omitting what is required for maintenance and by minimal and normal care.

It is not certain that removing life-sustaining nutrition and fluids in all instances would be immoral, but it is morally certain that withholding life-sustaining and medically providable food and water *risks* direct killing. Because of this, the more protective course of action would require that they be provided and should be taken.

When one allows another to die, one does not choose to introduce a new lethal cause, but merely permits a presently ex-

isting one to proceed without impediment. When one kills by benign neglect, one chooses a commission or omission that in fact introduces a new and previously inoperative lethal cause to bring on death.

It has been mentioned in private that some responsible moralists hold that one can intend another good while only foreseeing death resulting from the removal of food and water. However, how can an action that makes death certain, that does not save another's life by its performance, be accepted under traditional principles of double effect.

The principle of double effect cannot be applied to the removal of life-sustaining and medically providable nutrition and fluids such that one can argue that one is only removing a burdensome treatment and not intending death. Their removal makes death certain, and it

is not clear how one can make such a choice to withhold hydration or feeding without an intention to kill a person, at least when others are not immediately involved. If the lives of other parties were involved, or if it were a case of self-defense, then it might be morally possible to withdraw food in the absence of a directly lethal intention. But it is not clear how one could reject life-sustaining, medically providable food and fluids without intending one's own death. Such an action would be morally equivalent to removing an oxygen mask from a patient and putting a plastic bag over his or her head on the claim that the oxygen mask was too burdensome. It is not morally important that death came by omission in one case and commission in another.

If one argues that the burden of feeding is so great that it could be withdrawn, then one would seem to be logically more committed to providing it as the burdens of withdrawing it mount. If pain is to be a criterion for withholding it, then it would only be fair to use pain as a criterion for providing it. If a person were to experience great pain as a result of the withholding of feeding, it would seem imperative to provide it if that would be the most efficient way of alleviating the pain, and the use of painkillers to alleviate the pain of starvation or dehydration could very well be immoral because they would be eliminating pain caused by a lethal condition that was purposefully introduced.

Financial reasons also do not justify removing food and fluids. No sound, reliable, and accurate figures have ever

been provided about the number of persons who need assisted feeding in this country. If assisted feeding could be removed because of cost, then other simple medical treatments, such as insulin, could also be removed for being too costly. In those instances where individuals or families experience financial hardship because of the cost of feeding another, there is no sound reason why social policies could not be changed to compensate them for their burdens or losses.

In addition, IV, NG, or stomach tube feeding over the long term does not impose an extraordinary burden either. However, if assisted feeding could be considered an extraordinary burden over the longer term, even though it would sustain life, why would not treatments that impede but do not cure incurable

conditions such as insulin injections be extraordinary? How one would translate this principle into a legal norm is not at all clear. If one is to argue this, then it would also seem fair to argue that other more expensive forms of care, such as hygenic care or physical therapy, could be withheld even though they would benefit the patient.

There is a serious moral-legal issue involved in establishing ethical principles governing the provision of assisted feeding. Some hold that the morality of providing assisted feeding should be separated from the public policy aspects of its provision. This view of the ethical responsibilities is somewhat truncated, however, because one basic aim of this ethical analysis is to establish the grounds of an ethical public policy. Thus, ethical principles governing the

administration of this form of care should be capable of supporting a public policy that will adequately protect medically vulnerable patients from being starved or dehydrated to death by intention or by benign neglect.

Some have claimed that feeding the persistently unconscious is useless. They claim that only those who have a reasonable chance to recover neurological functioning should be given assisted feeding. This is objectionable because, while there are circumstances where nutrition and fluids can improve neurological functioning, this is only an indirect and remote function of nutrition and fluids. The primary aim in providing food and water is to sustain natural organic operations and defenses, and hydration and feeding is of use and of benefit when they can do this. Improving neurological

functioning is only a secondary aim in providing these, and food and water should not be considered useless if they can sustain life, but do not improve neurological functioning.

Nutrition and fluids are only of no benefit when a patient is at death's doorstep and when they cannot sustain life by their provision. The view that nutrition and fluids must have a positive impact on a person's neurological functioning should not have a bearing on decisions to provide them. To require that providing food and water have a positive neurological impact presumes a quality of life judgment that discriminates on the basis of neurological capacity.

There are situations where food and fluids can be dangerous to a patient, and, in those circumstances, their provision should be limited, but clinical

problems associated with their provision should not be a justification for the definitive and absolute denial of food and water. Where there are difficulties in providing them, it would be justified to modify their provision, but these circumstances would not justify the definitive and absolute denial such that a new and independent lethal condition was imposed on the patient.

DOCTORS HEAL, SORCERERS KILL

Unlike shamans, priests, and witch doctors, who achieved their results through supernatural means and rituals, the sorcerer did not depend on psychic powers and magic rites alone. He employed natural means as well. These consisted of a stock of drugs, empirically accumulated by the sorcerer himself through knowledge gleaned from the study and use of natural products. As a consequence, the sorcerer, in primitive times, was the chief possessor of knowledge of the beneficial and baneful properties of plant and animal derivatives.[1] His knowledge of the salutary and harmful effects of natural substances was not sim-

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[1] de Wall Malefijt, A. *Religion and Culture. An Introduction to Anthropology of Religion.* Macmillan, New York, 1968, pp. 237, 243-4, 274-5.

ply for the purpose of promoting one effect and avoiding the other. Both usages were reflected in his pharmacopoeia.

Primitive man had no concept of death as a natural occurrence. In these early times, illness was attributed not only to disfavor of the gods and to evil spirits but also to the instigation and malignant activities of other human beings – enemies – working through the arts of sorcery and witchcraft.

Often one died because – it was thought – one was doomed by another. Not until the Hippocratic treatise on *The Sacred Disease*[1] – wherein Hippocrates challenged the belief that epilepsy was an affliction of the gods and maintained instead that *all* disease arose from natural causes – was the last vestige of

[1] Hippocrates, *The Sacred Disease*. In W. H. S. Jones (Trans.). Loeb Classical Library, Putnam, New York, 1923, pp. 139-83, Vol. 2.

primitive man's concept removed, at least in enlightened circles.

Prior to this Hippocratic treatise, cures were achieved either by treating the supernaturally afflicted individual or by taking action against the persecutor.[1] The sorcerer, as the prescriber of drugs, thus had a double utility. He functioned both as healer and killer – to treat the effect in the patient or to eliminate him who cause the effect, the malevolent human agent. He was available for either task on a fee basis.[2]

The contradictory goals of the sorcerer's skills and the schizophrenic nature of his activities ultimately became a source of insecurity to society as a whole. Plato expressed this concern in his discussion of laws pertaining to pun-

[1] *Ibid.*, pp. 248-9.
[2] Margotta, R. *History of Medicine*, Paul Hamlyn, Middlesex, England, 1968, pp. 16-7.

ishment in "cases in which a person intentionally and of malice harms another with meats, or drinks, or ointments.[1]

In the context of this Greek position on legal punishment, Dr. Margaret Mead, anthropologist, adds a profound observation: that the Hippocratic Oath marked one of the turning points in the history of man. She states,

For the first time in our tradition there was a complete separation between killing and curing. Throughout the primitive world the doctor and the sorcerer tended to be the same person. He with power to kill had the power to cure …. He who had the power to cure would necessarily also be able to kill.

With the Greeks, the distinction was made clear. One profession, the followers of Asclepius, were to be dedicated

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1 Plato. *Laws XI*. 932, Jowett Translation.

completely to life under all circumstances, regardless of rank, age, or intellect – the life of a slave, the life of the Emperor, the life of a foreign man, the life of a defective child.

Mead stresses that

This is a priceless possession which we cannot afford to tarnish, but society always is attempting to make the physician into a killer – to kill the defective child at birth, to leave the sleeping pills beside the bed of a cancer patient, …

She is convinced that "it is the duty of society to protect the physician from such requests."[1]

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1 Quoted in Maurice Levine, M.D., *A Hippocratic Oath for Psychiatrists*, as a personal communication from Margaret Mead 1961. Paper delivered at a meeting of the Ohio Psychiatric Association in Cincinnati, Apr. 12, 1961. (Published in Levine, M. *Psychiatry and Ethics*. Braziller, New York, 1972.)

Today, society increasingly disregards Meads conviction that it is society's obligation to secure the physician from demands that compromise his role as a trustworthy protector of life. The acceptance of killing as a function of the physician not only exists in large segments of the laity and is widespread in government, but unfortunately is acquiesced to by large segments of organized medicine which suffer from a recurrent tendency to be seduced by financial gain.

By this failure society is now recycling today's obstetrician back to the dark ages of the sorcerer. For a fee he, too, has a double utility: he will kill – or rescue – the smaller of two patients in a pregnancy on the basis of the woman's request. Tomorrow it will be the surviving child's turn to request and to pay the accommodating "sorcerer-physi-

cian" to dispatch, under the euphemism of euthanasia, his troublesome elderly parent.

It is the Oath – a code of ethics which holds steadfast to a moral obligation in conformity with the definitive nature of a learned profession (here medicine) – which is the prime protector of the purity of the medical art. By imposing on its members an obligation to remain resolute against the assault of a sick society, the Oath, properly constituted, becomes the one hope of preserving the unconfused role of the physician as healer.

COONS RECOVERS IN NICK OF TIME,

LOVE FOR FOOTBALL HEALS BIKER

"A judge has withdrawn his permission for removal of a feeding tube from a stroke victim because the woman's condition improved.

Over the weekend, the woman – Carrie A. Coons, 36, of Rensselaer, N.Y., who had been declared to be in an "irreversible" vegetative state – began talking and eating on her own.

She had been unconscious in a hospital in Albany since November, a few weeks after suffering a stroke and cerebral hemorrhage.

Coons was the first New Yorker for whom a right-to-die petition had been approved since last year, when the state's highest court authorized the removal of feeding tubes in cases in which the

wishes of an incompetent patient could be proved.

Justice Joseph Harris of state Supreme Court approved the petition last week – but vacated his order Tuesday after a doctor testified that the woman had become alert over the weekend.

The doctor said that when Coons had been told of the legal question, she expressed ambiguity about whether she would want the feeding tube removed even if she lapsed back into unconsciousness. She commented, "These are difficult decisions" and lapsed back into sleep, the doctor said.

Coons' case has baffled her doctors, her lawyers and her sister, 38, who had sought removal of the feeding tube.

Doctors who specialize in right-to-die cases agreed that the case was exceptional and should not necessarily have an

undue influence on other families caught up in similar dilemmas. The doctors also said the Coons case illustrated that medical declarations were fallible.

"It's a dramatic case; it shows you that you're basically never dealing with certainties here," said Dr. Ronald E. Cranford, a neurologist in Minneapolis, a past president of the American Society of Law and Medicine and a consultant to a White House commission on right-to-die issues. Dr. Cranford has had at least two of his own patients unexpectedly regain consciousness.

"What you are dealing with, though, is degrees of probability, usually very high degrees of probability."

Biker Shakes Coma

In Denver, Brent Doyle, 18, who was injured in a motorcycle accident, says

words of encouragement recorded by Miami Dolphins quarterback Dan Marino helped pull him out of his three-month coma.

"I think Dan Marino is just the greatest football player there is, and the tape I got from him was really good encouragement," Doyle said. He is preparing to leave today the Mediplex Rehab Hospital in Thornton, Colo., a suburb of Denver.

Doyle said Wednesday that on the tape, Marino "just said, 'You can snap out of it. Just keep up the hard work. Me and all the Dolphins are cheering for you 100 percent. If you get better soon, you can watch the Dolphins, and you can watch me perform.'"

Don Doyle, Brent Doyle's father, said he had played Marino's recorded message for his son daily, often two or three times, over the course of the coma.

The younger Doyle suffered serious head injuries in October when he lost control of his motorcycle while riding through the Rocky Mountains foothills west of Boulder. In mid-February, a little more than two months after receiving Mariano's taped message, Doyle emerged from the coma.

Dr. Joshua Yurfest, a physician at Mediplex, said the "talk therapy" that Doyle received was controversial among doctors, who refer to it as "coma stim" - short for coma stimulation.

"We believe it makes a difference, but we don't know," Yurfest said."

Reprinted from the *Post Dispatch*, 4/14/89 page 2A (St Louis)

CONCLUSION

The Court should not reverse.

Respectfully submitted, Robert L Sassone
Attorney for Butler

NO 88-1503
IN THE SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1989

NANCY BETH CRUZAN, BY HER PARENTS AND CO-GUARDIANS, LESTER L AND JOYCE CRUZAN
Petitioners,
v.
DIRECTOR OF MISSOURI DEPARTMENT OF HEALTH, AND ADMINISTRATOR OF THE MISSOURI REHABILITATION CENTER AT MT. VERNON,
Respondents,
v.
THAD C. McCANSE, GUARDIAN AD LITEM,
Respondent.

Affidavit of mailing of amicus brief copies, Rule 28.2

State of California }ss.
City of Santa Ana, County of Orange }

Robert L Sassone, being first duly sworn on his oath deposes and says:

Robert L Sassone is a member of the bar of the United States Supreme Court admitted October 26, 1971. To his knowledge, on October 11, 1989, within the particular time and permitted time for serving of said amicus brief pursuant to Rule 28.2, he deposited in the United States Mailbox at Santa Ana, CA 92701 pursuant to Rule 28.2 with first class postage prepaid 40 copies of the attached amicus brief in the present case properly addressed to the Clerk of the United States Supreme Court and three copies of said amicus brief to each party addressed as follows:

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Subscribed and sworn to before me on
October 11, 1989,

Lawrence D Sassone, Notary Public